

# CHILD DEATH INVESTIGATION CHECKLIST

Michigan Department of Human Services

**Note:** CPS must take steps to ensure the safety of any surviving children, as soon as possible.

## CHILD, CAREGIVER AND FAMILY DEMOGRAPHIC INFORMATION

Child's name:	Date of birth:
Child also known as:	Date of death:
Race/ethnicity of child (Caucasian, African American, American Indian, Asian, Hispanic, Bi-racial [Specify], Other):	Child's sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address where child was found unresponsive:	
Address(es) where child has been in the last 12 hours:	
Who was responsible for child at time of death (list name and address):	
Was that person a minor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who has legal custody of child (list name and address):	
Who does child primarily live with (list name and address):	
Other care providers, e.g., child care providers, babysitters, relatives, etc. (list name and address):	
Was anyone else present in the home when the child died (list name and address):	

## FAMILY AND SOCIAL CONDITIONS

Number of persons living at scene:	Number of individuals under 18 years of age living at the scene:
Is the site of the incident or death scene a licensed child care or other child care setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: <input type="checkbox"/> Licensed Child Care <input type="checkbox"/> Unlicensed Child Care <input type="checkbox"/> Licensed Foster Care <input type="checkbox"/> Relative's Care <input type="checkbox"/> Other	
How many children were under the care of the provider at the time of incident or death?	
Does child go to daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Licensed <input type="checkbox"/> Non-licensed <input type="checkbox"/> Relative	
Name and address of child care provider(s):	
Are there any cultural practices that may have contributed to the death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe:	

## CHILD'S HEALTH HISTORY (OBTAIN MEDICAL RECORDS)

Source of medical information:					
<input type="checkbox"/> Doctor	<input type="checkbox"/> Other Health Care Provider	<input type="checkbox"/> Medical Record	<input type="checkbox"/> Parent/primary caregiver	<input type="checkbox"/> Family	<input type="checkbox"/> Other
Name(s) of child's health care provider(s):					
Has the child been sick in the last 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:			Was child taken for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where or to whom?		
Has the child had any serious illness or injury in the past? (E.g., lung disease, heart disease, stopped breathing, seizures, broken bones, head injuries, other illness, other injuries or allergies.)					
Did child have any health issues when born? <input type="checkbox"/> Yes <input type="checkbox"/> No Prenatal drug or alcohol exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No			Any birth defects? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:		
Has child received appropriate well visits? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has child ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why and where?					
Describe any family history (immediate or extended) of infections, mental illness, pneumonia, prematurity, birth defects, trauma, other infants who died suddenly, other medical issues?					
Have any family members or others who have been around the child been reported for past child abuse/neglect or domestic violence, been in the foster care system, or been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Review any DHS history and verify criminal history. Document results in Investigation Report (DHS-154).					

## CONDITION OF CHILD

Describe condition/behavior of child during the last 24 hours:	Describe anything unusual with the child's behavior or appearance?
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## When Last Known Alive

Time the child was last known alive: By whom? (list name and address):
Explain how it was known the child was still alive:
What was the child wearing when last known alive?

## When Found Unresponsive

Time the child was found unresponsive:

By whom? (list name and address):

Describe child's condition when found unresponsive? (E.g., breathing, not breathing, choking, etc.)

What did the child feel like when found unresponsive?

☐ Sweaty    ☐ Limp, flexible    ☐ Rigid, stiff    ☐ Warm to touch    ☐ Cool to touch    ☐ Other, specify below    ☐ Unknown

What was the child wearing when found unresponsive?

a. If infant, was the infant tightly wrapped or swaddled?    ☐ Yes    ☐ No    e. Any discoloration around the face, nose or mouth?    ☐ Yes    ☐ No

b. Were there any secretions? (foam, froth)    ☐ Yes    ☐ No    f. Any pressure marks? (pale, blanching)    ☐ Yes    ☐ No

c. Any rash or unusual marks on the skin, e.g., small, red blood spots on skin, membranes or eyes?    ☐ Yes    ☐ No

d. Were there any birthmarks or injuries of any type, including bruises, scrapes, burns, diaper rash, unusual marks, etc.?    ☐ Yes    ☐ No

If yes to a-f above, describe:

## POSITION OF CHILD

### When Last Placed

Where was the child last placed? (bassinette, crib, car seat, adult bed, swing, child's bed, etc.):

In what room and what proximity to people?

## Infants

In what position was the infant last placed?

☐ Sitting    ☐ Back    ☐ Right side    ☐ Left side    ☐ Stomach    ☐ Other    ☐ Unknown

Was this the infant's usual position?    ☐ Yes    ☐ No    If no, list usual position:

What was the infant's **face** position when last placed?

☐ Face Down    ☐ Face Up    ☐ Face Right    ☐ Face Left    ☐ Other    ☐ Unknown

What was the infant's **neck** position when last placed?

☐ Hyperextended    ☐ Flexed    ☐ Neutral    ☐ Turned    ☐ Other    ☐ Unknown

## When Found Unresponsive

Where was the child found unresponsive? (bassinet, crib, car seat, adult bed, swing, child's bed, etc.)

In what room and what proximity to people?

In what position was the child found unresponsive?

☐ Sitting ☐ Back ☐ Right side ☐ Left side ☐ Stomach ☐ Other ☐ Unknown

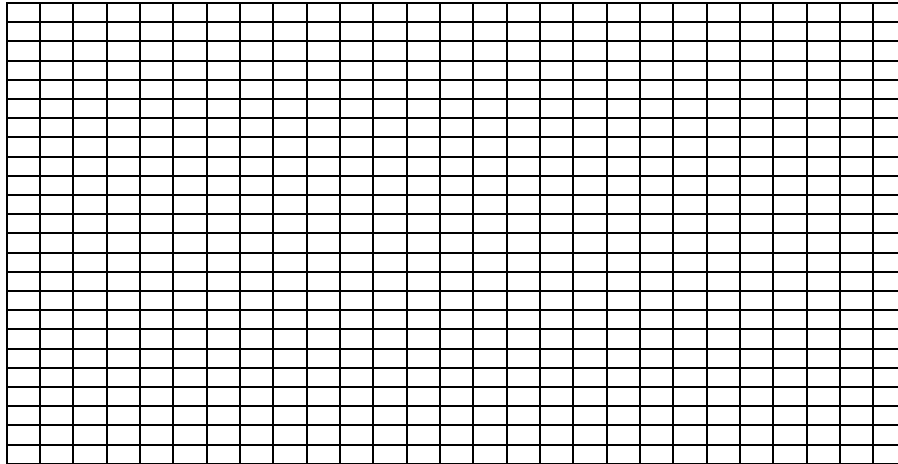
Was this the child's usual position? ☐ Yes ☐ No If no, list usual position:

What was the child's **face** position when found unresponsive?

☐ Face Down ☐ Face Up ☐ Face Right ☐ Face Left ☐ Other ☐ Unknown

Draw the following: Child's position when last placed and when found. Indicate direction of child's head.

N  
W — E  
S



Was it hard to get child out of a space?

☐ Yes ☐ No

Was the child's body pinned?

☐ Yes ☐ No

If pinned, how was the child's body pinned?

Explain:

## POSSIBLE OBSTRUCTIONS

List all materials and objects near child when found, including blankets, sheets, pillows, bumper pads, other covers, stuffed animals, toys, household objects, etc.:

Was child sleeping alone? ☒ Yes ☐ No

List all persons sleeping with child – name, age, height, weight, and location in relation to infant:

Name	Age	Height	Weight	Location

When child was found unresponsive, were any arms, legs or other parts of a person(s)' body covering child? ☐ Yes ☐ No If yes, describe?

Were person(s) sleeping with child intoxicated at the time? ☐ Yes ☐ No If yes, describe?

Was there recent alcohol or other drug consumption by person(s) sleeping with child? ☐ Yes ☐ No If yes, describe?

Blood/urine results:

Breathalyzer results:

Were person(s) sleeping with child overtired at the time? ☐ Yes ☐ No If yes, describe?

**ENVIRONMENTAL CONDITIONS (PHOTOGRAPH AND EVIDENCE COLLECTION)**

Current temperature in the room where the child was found unresponsive:

**Thermostat setting:****Thermostat reading:****Outside temperature:**

Heating or cooling sources being used at time of death:

- |   |  |  |   |   |   |
|---|--|--|---|---|---|
| <input type="checkbox"/> Central Air        | <input type="checkbox"/> A/C Unit                | <input type="checkbox"/> Ceiling Fan     | <input type="checkbox"/> Floor/Table Fan    | <input type="checkbox"/> Window Fan       | <input type="checkbox"/> Open Window(s) |
| <input type="checkbox"/> Gas Furnace/Boiler | <input type="checkbox"/> Electric Furnace/Boiler | <input type="checkbox"/> Space Heater    | <input type="checkbox"/> Baseboard Heater   | <input type="checkbox"/> Electric Radiant |   |
| <input type="checkbox"/> Fireplace (Wood)   | <input type="checkbox"/> Fireplace (Coal)        | <input type="checkbox"/> Kerosene Heater | <input type="checkbox"/> Wood Burning Stove | <input type="checkbox"/> Other            | <input type="checkbox"/> Unknown        |

Where was the child found in proximity to the heating/cooling source?

Describe the general appearance of the scene (cleanliness, hazards, overcrowding, etc.):

Describe any environmental hazards at the scene (e.g., insects, smokey smell, dampness, mold growth, pets, peeling paint, rodents or vermin, odors or fumes, presence of alcohol containers or drug paraphernalia, prescription or over the counter drugs, electric hazards near the crib, other):

**INVESTIGATOR ACTIVITIES**

Times: Law enforcement at scene am/pm

Times: Child at hospital am/pm

Other investigators at scene: Times: am/pm

Transported to a medical facility? ☐ Yes ☐ No

If yes, name and address of EMS/first responder:

Interview/coordination with law enforcement? ☐ Yes ☐ No Describe (include name of law enforcement agency and officer(s)):Contact/Interview with the medical examiner? ☐ Yes ☐ No Describe (include name of medical examiner office and medical examiner):If more than one person was interviewed, does the information differ? ☐ Yes ☐ No

Detail any discrepancies of relevant information:

Does the caregiver's explanation fit with investigative findings? ☐ Yes ☐ No Describe:

\* See CFP 713-8, Special Investigative Situations, Child Death section for more information on completing child death investigations.